MODEL CRIMINAL ENFORCEMENT STATUTES FOR MANAGED CARE

National Association
of
Medicaid Fraud Control Units

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Preamble

The move in Medicaid from a predominantly fee-for-service mode to a managed care or capitated model presents a challenge for states that wish to curb fraud and abuse in their Medicaid programs. Although the fifty states vary in the manner by which they are introducing managed care into their Medicaid programs, more than thirty percent (30%) of the nation's Medicaid recipients are in managed care programs at this writing, and the percentage is increasing rapidly. The universally expressed concern of the states having managed care experience is that fraud and abuse in managed care has resulted in a decreased quality of services to the recipients (underutilization), and loss of integrity in both the program and contracting providers (bribery and graft). It has become painfully apparent that managed care cannot and will not eliminate fraud and abuse in the health care system.

Medicaid fraud in a fee-for-service climate has traditionally involved violations punishable by false claims statutes, such as submitting claims for services that were either not rendered or not necessary. In a capitated structure, however, providers do not submit service-specific claims. Providers will be paid a fee which will not vary regardless of the number of services rendered. Unscrupulous providers will defraud the program by providing as few services as possible, or by treating only the healthier patients. Even where adequacy of care is policed by requiring providers to maintain records of their encounters with patients, the submission of false encounter data, although devastating to the program's quality assurance goals, is not subject to prosecution under a false claims theory.

To assist sovereigns in addressing these issues, the National Association of Medicaid Fraud Control Units adopted this model criminal legislation in October, 1996. The purpose of these statutes is to provide a framework in which states may redress fraud in a managed care environment by means of criminal prosecution. In considering the adoption of any or all of the proposed model, states should examine their respective existing laws with regard to false claims, false statements, unfair competition, unfair business and deceptive marketing, and antitrust to determine whether new laws are needed. Even if a creative reading of current state laws may arguably support the prosecution of fraud within managed care plans, states may find it advantageous to adopt some or all of the model statutes so that prosecutorial agencies and courts may draw upon the experiences of other states adopting the model statutes.

These statutes are not intended to provide civil, administrative, or injunctive remedies, all of which may be important statutory tools in the states' efforts to curb fraud and abuse.

I. Health Care Fraud

Purpose: To make criminal fraudulent behavior as it applies to a managed health care delivery system

(a) Whoever, with the intent to appropriate to himself or to another a benefit worth $500 or more, knowingly executes or conspires to execute a scheme or artifice

> (1) to defraud any state or federally-funded or mandated health plan in connection with the delivery of, or payment for, health care benefits, items, or services; or
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> (2) to obtain by means of false or fraudulent pretense, representation, statement, or promise, money or anything of value in connection with the delivery of or payment for health care benefits, items, or services which are in whole or in part paid for, reimbursed, subsidized by, or are a required benefit of, a state or federally-funded or mandated health plan.

shall be guilty of a felony and fined up to $10,000, imprisoned for not more than five years, or both.

(b) Whoever, with the intent to appropriate to himself or to another, a benefit worth less than $500 in the aggregate, knowingly executes or conspires to execute a scheme or artifice more fully set forth in item (a), shall be guilty of a misdemeanor and fined up to $5,000, imprisoned for not more than one year, or both.

(c) Anyone who attempts to execute a scheme or artifice set forth in this section shall be guilty of a misdemeanor and fined up to $5,000, imprisoned for not more than one year, or both.

(d) Anyone causing death or serious bodily injury to a person who is enrolled in a health plan described in this section as the result of executing a scheme or artifice described in section (a) with gross negligence or reckless disregard of human life shall be punished by imprisonment for life or any term of years, and a fine of up to $50,000, or both.

(e) As used in this section, the term "health plan" includes:

> (i) any government-sponsored health care reimbursement plan, and
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> (ii) any private insurance carrier, health care cooperative or alliance, health maintenance organization, insurer, organization, entity, association, affiliation, or person which contracts to provide or provides goods or services that are reimbursed by or are a required benefit of a state or federally-funded health benefits program, and
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> (iii) anyone who provides or contracts to provide goods and services to an entity described in subsections (e)(i) and (e)(ii) of this section.

(f) For purposes of section (a)(2), covered representations and statements include, but are not limited to, reports, claims, certifications, acknowledgments and ratifications of financial information, enrollment claims, demographic statistics, encounter data, health services available or rendered, and the qualifications of persons rendering health care and ancillary services.

Commentary

Anticipated coverage: Makes it a crime to defraud a state or federal health care program. Also makes it a crime to defraud any provider of health care services if that provider receives funds from any state or federal medical insurance program or grant. Section (a) (2) also covers claims for fictitious enrollees and the falsification of demographic data in order to obtain higher capitation rates.

Notes: The proposed statute is modeled after the mail fraud statute, 18 U.S.C. §1341. It proscribes any scheme to defraud a state or federally-funded health care program. Examples of fraud which may be prosecuted under this model statute include claiming capitated payments for fictitious enrollees, fraudulently increasing capitation payments by misstating enrollees' diagnoses, fraud in a cost-report based reimbursement setting, and fraud committed by subcontractors within the managed care system.

Although the model provides coextensive coverage with many Medicaid fraud and false statements statutes, it necessarily expands the coverage of such statutes to include the filing of a false statement that does not result in an immediate or direct reimbursement under a managed care health system. For example, if a managed care provider files overstated encounter data in the present year, the effect of the fraud may not be fully realized until some time in the future, i.e., by increasing future years' capitation rates.

Subsection (e)(iii) covers non-health care subcontractors and vendors who defraud state or federally reimbursed health care providers. To the extent that any managed care provider is reimbursed for, or rates are determined on the basis of, historical costs, fraudulently inflated subcontractor charges (e.g., maintenance or construction costs) will affect the rate setting process.

Subsection (b) provides for a felony threshold of $500, which may be adjusted to be consistent with a state's statutory scheme. Many state false claim and theft statutes are structured to differentiate the seriousness of crimes based upon the amount of money involved, and that structure is followed in this section. Benefits derived from a single scheme or pattern of fraud may be aggregated in determining whether the felony threshold is met.

Subsection (d) recognizes that a managed care delivery system may be inappropriately rewarded through its failure to provide necessary medical services. It accordingly seeks to significantly deter any act which would adversely affect care for the covered population. The standard to be applied is that of gross or criminal negligence with respect to acts performed or omitted.

If recoupment is not already a part of the regulatory fabric, the legislature should provide for recovery of any amounts overpaid as the result of the deception, and consider trebled damages, civil penalties, and/or other remedial measures designed to make the program whole.

The legislature should also recognize that discovery, investigation and prosecution of complex fraud schemes may take several years and should accordingly provide for a statute of limitations of not less than three years, even for crimes involving less than $500.

II. Bribery and Graft in Connection with Health Care

Purpose: To make criminal corrupt behavior in obtaining and administering health care contracts

(a) Whoever

(1) directly or indirectly gives, offers, or promises anything of value to a health care official, or offers or promises a health care official to give anything of value to another person, with intent

(a) to influence or reward any acts or decisions of any health care official exercising any authority in any state or federally-funded or mandated health plan, or

(b) to influence such official to commit or aid in the commission or conspire to allow any fraud in a state or federally-funded or mandated health plan, or

(c) to induce such an official to engage in any conduct in violation of the lawful duty of such official; or

(2) being a health care official, directly or indirectly demands, solicits, receives, accepts or agrees to accept anything of value personally or for any other person or entity, the giving of which would violate paragraph (1) of this subsection.

(3) Penalties: Any person found guilty of this offense shall be guilty of a felony, imprisoned for not more than 5 years, and fined up to $10,000.

(b) as used in this section -

(1) the term "health care official" means

(a) an administrator, officer, trustee, fiduciary, custodian, counsel, agent, or employee of any health plan;

(b) an officer, counsel, agency, or employee of an organization that provides, proposes to, or contracts to provide services to any health plan;

(c) an official, employee, or agent of a state or federal agency having regulatory or administrative authority over any health plan;

Commentary

Anticipated coverage: Punishes the offering or receipt of bribes which are intended to influence decisions affecting the administration of any state or federal health insurance program, regardless of whether the official is employed by the health plan, a supplier or contractor to the health plan, or a governmental agency having oversight authority.

Notes: This section is similar in design and effect to Title 18, §201 of the United States Code. It proscribes the offering or receipt of any benefit which is not allowed by law in connection with the administration or provision of health care programs. The model statute recognizes that, in addition to all traditional bribery motives, fraud within a managed care system may also be

Commentary

Anticipated Coverage. The statute covers areas previously addressed by Medicaid Fraud statutes which punish the making of any false statement in connection with a claim for benefits, as well as schemes involving fictitious enrollees. It also punishes the filing of false encounter data or other required reports in a managed care setting.

Notes. Adapted from, and closely following the language of, the Federal False Claims Act, §1001 of Title 18 of the United States Code (1976).

May be used to prosecute many of the same crimes proscribed by Section I of this Model, but extends coverage to those filings which do not result in the payment of a benefit to the provider or contractor. Examples of additional areas covered by this section include the filing of any overstated or falsified encounter data, misstatements regarding the licensure or qualifications of the health plan's subcontractors, geographical coverage, outreach effort reports, and other indicators of quality assurance.

The statute is intended to punish not only the person making the false statement, but also the person who knowingly uses any document containing a false statement authored by another.

IV. Unfair or deceptive marketing practices.

Purpose: to prohibit any unfair or deceptive marketing practices in connection with the offering of health care services and health plans.

(a) It is unlawful to engage in any unfair or deceptive marketing practices in connection with proposing, offering, selling, soliciting, providing, any health care service or any health plan.

(b) Unfair or deceptive marketing practices include:

> (1) False, misleading oral or written statement, visual description, advertisement, or other representation of any kind which has the capacity, tendency, or effect of deceiving or misleading health care consumers with respect any health care service, health plan or health care provider.

Commentary

Anticipated Coverage. This section is intended to make criminal the various unfair and deceptive marketing practices which have been identified in connection with the marketing of health plans.

Notes. Unfair and deceptive marketing practices identified include misrepresentation of the quality and content of services offered and the use of confidential welfare recipient information in the enrollment process. Marketing abuses will occur wherever enrollees are provided with the opportunity to chose between health plans.

Section (b) (5) prohibits offering inducements which are not related to patient care, but recognizes that some Medicaid and Medicare health maintenance plans are permitted to offer enrollees more medical benefits than the traditional fee-for-service plan. For example, Maryland's Medical Assistance program does not provide dental coverage for adults, but allows contracting health maintenance plans to offer this additional coverage to enrollees as an inducement.

Section (b)(6) should refer to relevant state confidentiality statutes.

V. Enhancement of penalties for corporate defendants

Purpose: To allow for the assessment of enhanced monetary penalties where the violator is an entity.

(a) If the defendant found to have violated any provisions of sections I through V of this subtitle is an organization, then it shall be subject to a fine of not more than $50,000 for each misdemeanor, and not more than $250,000 for each felony.

(b) "Organization" means a person other than an individual. The term includes corporations, partnerships, associations, joint-stock companies, unions, trusts, pension funds, unincorporated organizations, governments and political subdivisions thereof, and non-profit organizations.

Commentary

Notes: The penalties provided in sections I through V of this title are intended to punish, rehabilitate, and deter individual defendants. In a managed care and other prevalent health care systems, however, providers may be large corporate entities which cannot be jailed and will not be deterred by the smaller fines intended for individuals. Therefore, states should consider enhancing penalties in cases where the defendant is a corporation.

It has been recognized that a corporation may be treated differently at sentencing than individuals. "(B)ecause corporations cannot be sentenced to prison time, sentences between corporate and individual defendants may be disparate..." *United States v. Blue Mountain Bottling Co. of Walla Walla,* 929 F. 2d. 526, 528 (9th Cir. 1991).

States must also be aware that existing remedial and enhancement alternatives, such as trebled damages or civil monetary penalties (e.g., $2,000 penalty for each false claim), are based upon a claims-driven health care system. In the managed care setting, there may be no claims on which to base a civil monetary penalty, and the state may not be able to quantify damage to the program.

The definition at subsection (b) is drawn from Section 18 of Title 18, United States Code and Section 8A1.1 of the Federal Sentencing Guidelines Manual.

VI. Electronic surveillance

Purpose: to permit electronic surveillance during an investigation for suspected health care fraud

(a) It is lawful under this subtitle for an investigative or law enforcement officer acting in a criminal investigation, or any other person acting at the prior direction and under the supervision of an investigative or law enforcement officer to intercept a wire, oral, or electronic communication in order to provide evidence of the commission of the offense of health care fraud, bribery, kickbacks for referring or refraining from referring a patient, or the making of false statements in connection with health care services, or any attempt, conspiracy, or solicitation to commit any of these offenses.

(b) Health care fraud, bribery, kickbacks for referring or refraining from referring a patient, and the making of false statements in connection with health care services shall have the same meanings as set forth in Sections I through IV of this subtitle.